

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Community Care on Palm		STREET ADDRESS, CITY, STATE, ZIP CODE 4768 Palm Avenue Riverside, CA 92501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three residents reviewed (Resident 1) was free from physical abuse when Certified Nursing Assistant (CNA) 1 slapped Resident 1 on the face.</p> <p>This failure had the potential for Resident 1 to suffer physical and emotional injury.</p> <p>Findings:</p> <p>On September 3 and 4, 2024, unannounced visits were made to the facility to investigate an allegation of physical abuse.</p> <p>On September 3, 2024, Resident 1 ' s record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and schizophrenia (a mental disorder that affects a person ' s ability to think, feel, and behave clearly).</p> <p>During a concurrent observation and interview on September 3, 2024, at 10:23 a.m., with Resident 1, Resident 1 was observed lying in bed, awake and alert. Resident 1 was verbally responsive and was Spanish speaking. The interview was conducted with the assistance of a Spanish speaking staff. Resident 1 stated a male nurse slapped him in the face in the dining area. Resident 1 could not remember the name of the male nurse. Resident 1 demonstrated how the male nurse slapped him in the face with an open hand. Resident 1 stated the slap was hard. Resident 1 stated a female nurse saw the male nurse slap him in the face. Resident 1 stated he had not seen the male nurse after the incident. Resident 1 stated he felt safe at the facility.</p> <p>During an interview on September 3, 2024, at 10:35 a.m., with the Social Service Designee (SSD), the SSD stated Resident 1 had a behavior of hitting the staff. The SSD stated if a resident had that behavior, the staff should have kept his distance from the resident and not hit back. The SSD stated she followed-up Resident 1. She stated Resident 1 did not have any emotional or behavioral changes.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on September 3, 2024, at 2:23 p.m., with CNA 2, CNA 2 stated she was walking in the hallway past room [ROOM NUMBER] and saw Resident 1 sitting in the wheelchair. Resident 1 was restless and tried to get out of the wheelchair. CNA 2 stated she saw CNA 1 grab Resident 1 ' s arms and force him to sit. CNA 2 stated Resident 1 tried to get out of the wheelchair again and CNA 1 put Resident 1 back in the wheelchair, and slapped him in the face. CNA 2 stated she was shocked by what she saw and called out CNA 1 ' s name. CNA 2 stated she told CNA 1 he should have not slapped Resident 1 ' s face. CNA 2 stated Resident 1 appeared like he was upset that he was slapped in the face. CNA 2 stated there was no redness or mark on Resident 1's face.</p> <p>During a telephone interview on September 4, 2024, at 8:36 a.m., with the Licensed Vocational Nurse (LVN), the LVN stated CNA 2 approached her and informed her she saw Resident 1 was trying to get out of the wheelchair and CNA 1 pushed him back in the wheelchair and slapped him in the face. The LVN stated she asked CNA 1 what happened. CNA 1 told her Resident 1 kept getting out of the wheelchair and he was worried Resident 1 would fall so he pushed him back in the wheelchair. She stated CNA 1 did not mention he slapped Resident 1. The LVN stated she went back and checked on Resident 1. The LVN stated there was no bruise or redness on Resident 1's face. She stated Resident 1 did not look scared or frightened. She stated Resident 1 told her he was not scared. The LVN stated Resident 1 was mad and upset he was slapped in the face.</p> <p>During an interview on September 4, 2024, at 1:03 p.m., with the Director of Nursing (DON), the DON stated the staff had an in-service on how to handle difficult and combative residents. The DON stated staff were aware to keep a distance when a resident started to be aggressive and strike at them. The DON also stated staff were aware to protect themselves and the resident. The DON stated she was not sure what triggered CNA 1 to slap Resident 1 in the face.</p> <p>A review of the facility document titled, THE RIGHTS AND PROTECTIONS OF A NURSING HOME RESIDENT, indicated, .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. They have the right to .Be Free from Abuse .Residents have the right to be free from verbal, sexual, physical, and mental abuse . The document was signed and acknowledged by CNA 1 on January 9, 2024.</p> <p>A review of the facility document titled, Abuse Prevention Program, revised December 2016, indicated, .Our residents have the right to be free from abuse .As part of the resident abuse prevention, the administration will .Protect our residents from abuse by anyone including but necessarily limited to .facility staff .</p>		